

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name _____

Date _____

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three to four weeks or longer:

- | | | | |
|----|--------------------------------------|-----------|----------|
| 1. | Chronic Cough (greater than 3 weeks) | Yes _____ | No _____ |
| 2. | Production of Sputum | Yes _____ | No _____ |
| 3. | Blood-Streaked Sputum | Yes _____ | No _____ |
| 4. | Unexplained Weight Loss | Yes _____ | No _____ |
| 5. | Fever | Yes _____ | No _____ |
| 6. | Fatigue/Tiredness | Yes _____ | No _____ |
| 7. | Night Sweats | Yes _____ | No _____ |
| 8. | Shortness of Breath | Yes _____ | No _____ |

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Date _____

Agency Employee Signature

Date _____

Health Care Provider (M.D., D.O., N.P.)